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Case report

Successfully treated bizarre self-mutilation with disembowelment – Case report with review of literature

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ABSTRACT

Self-inflicted abdominal stab wounds are generally uncommon and there is no published report of survivors after extensive self inflicted disembowelment with mutilation. Here we present a case of 28 year old male who was brought to hospital 2 1/2 h after disembowelment through self inflicted abdominal stab injuries. The patient had hypovolemic shock due to bleeding from the mesentery and a 450 cm segment of small bowel which had been pulled out from 2 abdominal stab wounds and slashed multiple times by him. He had alcohol intoxication and hallucinations and did not seem to be in pain or emotionally affected by the severe injury. After resuscitation, and emergency resection with anastomosis he had an uneventful post-operative recovery. On psychiatric evaluation during follow-up, he was found to have schizophrenia aggravated by alcohol abuse and was treated accordingly. As self mutilation can be the first presentation of a psychotic episode, a psychiatric evaluation is necessary for all patients with self inflicted injuries.

1. Introduction

Self-mutilation refers to deliberate, direct damage to body tissue without any conscious intent to commit suicide. These self- inflicted injuries may be as mild as hair plucking or as severe as amputation of body parts. However, self-inflicted abdominal stab wounds (ASW) are generally uncommon and those with deliberate disembowelment and mutilation rare. Although such self-inflicted ASW with disembowelment and mutilation leading to death has been reported[1], there is no published report of survivors after such an extensive injury. We report here a case of self-inflicted abdominal injury with bizarre disembowelment and mutilation, which was successfully treated. The reported patient did not have suicidal intent and was subsequently diagnosed to have schizophrenia and alcohol abuse disorder. The patient had a good outcome as he responded well to the surgery and psychiatric treatment.

2. Clinical presentation

A 28 year old male was brought at night by relatives to the Casualty department of our hospital for self inflicted abdominal wounds sustained 2 1/2 h earlier. The relatives had found the patient at night, quietly sitting in the room with intestine protruding from the abdomen, due to abdominal stab injuries he had caused himself with a kitchen knife. The relatives noted that he was not in agony despite the severe injury. Prior to this episode he had not attempted self-mutilation anytime. He was known to indulge in drinking alcohol over the past 4 years and had apparently consumed significant amount of alcohol before the incident. The relatives gave history suggestive of frightening auditory hallucinations in the patient during the previous 4 years, but no medical attention had been sought for the same. Subsequent police investigations confirmed that the injuries on the patient were self inflicted.

On examination he was in hypovolemic shock. The patient was conscious, alert but seemed unperturbed by the injury and did not seem to be in pain. He claimed that “voices” outside had ordered him to cause the injury. There was a large length of small bowel lying outside the abdomen with several lacerations and bleeding

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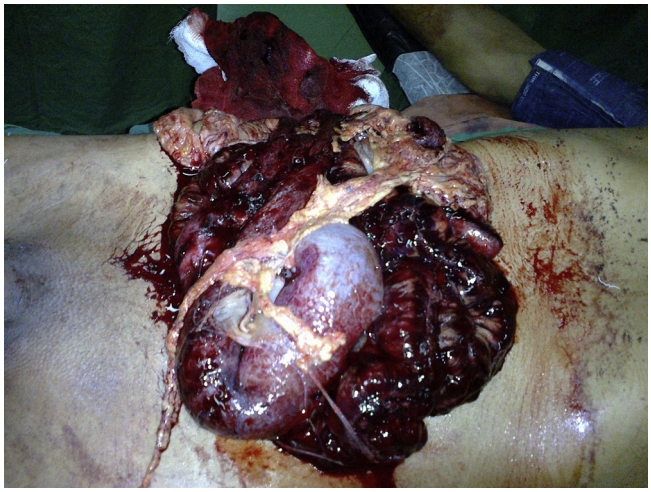

Fig. 1. Small bowel and mesentery brought outside the abdomen through self inflicted stab wounds.

points (Fig. 1). It was not possible to discern the abdominal wounds at initial assessment. During surgical exploration undertaken immediately after resuscitation, 2 transversely oriented stab wounds of 1 inch length each were seen around the umbilicus through which the intestines had been pulled out and slashed many times by the patient. At emergency laparotomy, 450 cm of small bowel was found lying outside the abdomen with multiple bowel perforations. There was also extensive injury to the mesentery with active bleeding. The injured small bowel was resected with anastomosis of the proximal 20 cm of jejunum to the distal 8 cm of ileum. The patient made an uneventful recovery after surgery. He also underwent psychiatric evaluation when his general physical condition stabilized. He was noted to have features of psychosis such as command hallucinations. He had not had any violent behaviour or self mutilation in the past. The preliminary assessment was that the present psychotic episode was consequent to alcohol abuse and/or a pre-existing schizophrenia. He was put on antipsychotic medications and advised a fresh revaluation after abstaining from alcohol abuse.

When he visited the hospital for follow-up 5 months later, he had stopped consuming alcohol but was not compliant with medications. Detailed psychiatric evaluation of the patient along with his family was done. The patient was from a broken family and had features of schizoid personality. He had no stable employment and had been indulging in drinking alcohol during the previous 4 years. He had persisting persecutory thought content and auditory hallucinations despite abstinence from alcohol, and hence a diagnosis of schizophrenia was made and treatment restarted. He was advised to have regular follow up.

3. Discussion

There is no published report of a patient surviving the bizarre self-inflicted mutilating injury of the kind described in the patient. A PubMed search using the terms “self inflicted injury” and “disembowelment” did not yield any report of survivors. Dawood[1] reported a suicide caused by injuries where 2 parts of the intestines 2 m and 2.5 m in length and mesentery were found on the ground with irregularly torn edges. Our patient did not have clear suicidal intent and did not have any other injuries that might indicate a determined suicidal intent.[2]

Self-inflicted abdominal stab wounds (ASWs) are uncommon. The probable reason for the rarity of self-inflicted ASW is that the abdomen is not perceived as a body area that if injured would lead to an immediate death.[2] Abdullah et al.[2] in a retrospective review of 23 patients with intentional self-inflicted abdominal stab wounds (ASWs) at two urban level I trauma centres during a 10-year period, observed that abdominal and retroperitoneal injuries due to self-inflicted ASWs were generally non-lethal but warranted surgical intervention.

Self-inflicted ASWs with disembowelment are more likely to result in fatality. Morita et al.[3] in their study of self-inflicted ASW in Japan classified them as simple stab wounds and wounds of Hara-kiri nature. Hara-kiri (Japanese ‘hara-kiri’: from ‘hara’ belly + ‘kiri’ cutting) is a ritual suicide by disembowelment with a sword, previously practiced in Japan by samurai as an honourable alternative to disgrace or execution. They found that 9 out of 84 self-inflicted ASWs were of Hara-kiri type and their mortality was significantly higher at 22.2% against 1.3% for non Hara-kiri type wounds.

The reported patient had self-inflicted disembowelment which is a major form of self-mutilation. Self-mutilation refers to the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent.[4] It can be as mild as hair plucking, to more severe but infrequent acts like enucleation, castration, and limb amputation. These major acts of self-mutilation cause great deal of tissue damage and blood loss and are associated with psychotic disorders and acute intoxications.[4] Both Abdullah and Morita did not report mutilating disembowelment and slashing of the intestines.

The patient in this report was subsequently diagnosed to have schizophrenia with alcohol abuse disorder which are risk factors for self-mutilation injuries. Abdullah et al.[2] noted that most patients were males (70%) with previous psychiatric history (74%) and half of the patients had a positive drug or alcohol screen. Our patient had caused the self-mutilating injury during the acute psychotic episode when auditory hallucinations ordered him to do so, although he did not have any suicidal intention. Schizophrenics are known to attempt self-harm due to command hallucinations, catatonic excitement or associated depression.[5] Wood et al.[6] stated that self-mutilation is a frequent occurrence in patients with schizophrenia and the mortality rate is higher among the schizophrenic group than that in the general population. Incidence of self-mutilation among alcohol dependent males is reported to be 29% and is attributed to impaired judgement and reduced inhibition.[7]

The reported patient survived as he responded well to the surgery and subsequent treatment. When a patient presents with a first episode of major self-mutilation, an underlying major psychiatric disorder must be looked for and treated to prevent further episodes.

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Conflict of interest
None.

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